MISSOURI VETERANS COMMISSION
MISSOURI VETERANS HOME

HEALTH CARE INFORMATION

INSTRUCTIONS

1. All information must be printed or typed. Attach additional sheets if necessary.
2. Form must be completed by licensed health care professional. Mail form to; (Check below)

☐ Missouri Veterans Home
1111 Euclid
Cameron, MO 64429
(816) 632-6010 FAX (816) 632-1361

☐ Missouri Veterans Home
2400 Veterans Memorial Drive
Cape Girardeau, MO 63701
(573) 290-5870 FAX: (573) 290-5909

☐ Missouri Veterans Home
#1 Veterans Drive
Mexico, MO 65265-0473
(573) 581-1088 FAX: (573) 581-5356

☐ Missouri Veterans Home
600 North Main
Mt. Vernon, MO 65712-1098
(417) 466-7103 FAX: (417) 466-4040

☐ Missouri Veterans Home
620 North Jefferson
St. James, MO 65559-1999
(573) 265-3271 FAX: (573) 265-5771

☐ Missouri Veterans Home
10600 Lewis and Clark Blvd.
St. Louis, MO 63136
(314) 340-6389 FAX: (314) 340-6379

☐ Missouri Veterans Home
1300 Veterans Road
Warrensburg, MO 64093
(660) 543-5064 FAX (660) 543-5075

GENERAL INFORMATION

PATIENT'S NAME			BIRTHDATE
PLACE OF RESIDENCE AT TIME OF APPLICATION			SOCIAL SECURITY NUMBER
CITY	STATE	ZIP CODE	TELEPHONE NUMBER ( )

HISTORY/PHYSICAL INFORMATION

HEIGHT	WEIGHT	REQUIRES NURSING HOME CARE? ☐ YES ☐ NO **NOTE:** CHECKING"**YES**" INDICATES VETERAN **IS** ELIGIBLE FOR NURSING HOME CARE. CHECKING **"NO"** INDICATES VETERAN **IS NOT** ELIGIBLE FOR NURSING HOME CARE.
DATE OF LAST TETANUS	DATE OF LAST PNEUMOVAX	HISTORY OF DRUG/ALCOHOL ABUSE? ☐ YES ☐ NO
IMMUNIZATIONS	SPECIFY ALLERGIES	HISTORY OF MENTAL ILLNESS? ☐ YES ☐ NO IF APPLICANT HAS A PSYCHIATRIC DIAGNOSIS, PLEASE ATTACH A COPY OF MOST RECENT PSYCHIATRIC EVALUATION.

ILLNESSES, SURGICAL PROCEDURES, HOSPITALIZATIONS

PRESENT CONDITION AS COMPARED TO ANY PREVIOUS EXAMINATION

DIAGNOSIS(ES)

MEDICATION

LIST ALL MEDICATIONS, DOSAGE AND FREQUENCY OF ADMINISTRATION OR ATTACH A COPY OF THE CURRENT PHYSICIAN ORDERS.

HEALTH CARE INFORMATION CONTINUED

FUNCTIONAL INFORMATION

CHECK IF PRESENT AND DESCRIBE IN "PERTINENT NURSING INFORMATION" SECTION

DISABILITIES

☐ Paralysis ☐ Amputation ☐ Contracture

IMPAIRMENTS

☐ Mentality ☐ Hearing ☐ Vision
☐ Speech ☐ Sensation

INCONTINENCE

☐ Bladder ☐ Bowel ☐ Saliva

ACTIVITY TOLERANCE LIMITATIONS

☐ None ☐ Moderate ☐ Severe

DEVICES/APPLIANCES

☐ Appliance ☐ Catheter ☐ Colostomy
☐ Cane ☐ Crutches ☐ Prosthesis
☐ Walker ☐ Chair, Type _____
☐ Wheelchair ☐ Geri Chair ☐ Side Rails
☐ Motorized Wheelchair/Scooter
☐ Special Matress, Type _____
☐ Special Cushion, Type _____

DIET

☐ Regular ☐ Low Salt ☐ Diabetic
☐ Bland ☐ Low Residue
☐ Tube Feeding ☐ Mechanical

MENTAL STATUS

	ALL THE TIME	FREQUENTLY	OCCASIONALLY	NEVER
Alert				
Forgetful				
Confused				

BEHAVIOR

Withdrawn				
Belligerent				
Suspicious				
Combative				
Noisy				
May Wander				

SKIN CONDITION

Diminished skin integrity (include redness).
Describe location, size, and treatment.

PERTINENT NURSING INFORMATION

Describe items checked in functional information and explain necessary details of care, diagnosis, medication, treatments, prognosis, teaching, habits, preferences, etc.

It is expected that the patient's condition within the next 6 months will:

☐ Improve ☐ Remain Static ☐ Deteriorate

Rehabilitation potential: Is the recipient at his maximum level of functioning?

If not, what improvements are expected in his functional capacity and self-care ability?

(a) Level of function to be attained _____

(b) Length of time it is expected to take to arrive at this _____

OTHER THERAPIES/TREATMENTS

	YES	NO	INDICATE SPECIFIC ORDERS
Physical Therapy	☐	☐	
Occupational Therapy	☐	☐	
Speech Therapy	☐	☐	
Respiratory Aids	☐	☐	
Oxygen Usage	☐	☐	
Intermittent	☐	☐	
Continuous	☐	☐	
Concentrator	☐	☐	
Tanks	☐	☐	
Nasal Cannula	☐	☐	
Mask	☐	☐	
Liter Flow	☐	☐	
Dressing Changes	☐	☐	

NAME OF EXAMINING PHYSICIAN **(PLEASE PRINT)**	DATE
SIGNATURE OF PERSON COMPLETING FORM	TITLE OF PERSON COMPLETING FORM
ADDRESS	TELEPHONE NUMBER ( )